HCFA MEDICARE • MEDICAID Health Care Financing Administration

Volume IV, Number 7 March 1999

HEALTH watch

Medicare Announces New Ambulance Coverage Regulation

The January 22, 1999 *Federal Register* contained a notice about a Medicare ambulance fee schedule to replace the current system of reimbursing suppliers based on their charges or costs. A final rule published in the January 25 *Federal Register* outlined new Medicare ambulance coverage requirements.

Medicare pays for medically necessary ambulance services only when other methods of transportation would endanger a beneficiary's health. To better achieve this goal, the new rule tightens requirements for determining medical necessity, requires better documentation from ambulance companies, and requires physician certification for non-emergency ambulance services.

Other provisions include minimum vehicle and staffing requirements and a definition of "bed-confined." The term bed-confined, as defined in the rule, applies to a beneficiary who is unable to get up from bed without assistance, unable to walk and unable to sit in a chair or wheel-

See **Ambulance,** page 6

Waiting-Time Disparities for Organ Transplant Recipients Reported

The Department of Health and Human Services (HHS) recently released a report that shows wide disparities in the length of time patients wait for organ transplants in different areas of the United States.

Under HHS regulations published last year, transplant professionals would be required to develop new policies for the transplant network to replace current allocation policies. The new policies would help assure that organs go to patients with the greatest medical need, in accordance with sound medical judgment and effective use of the organs. The current rules often require organs to be used in the local area where they have been procured, instead of being provided to patients with higher medical need, even when such patients may be located in nearby areas. The regulations are scheduled to become effective on October 21, 1999, and the Congress of Medicine has been asked by Congress to review the effect of the regulations. A reformed system that allocated organs on the basis of medical criteria, without arbitrary geographic constraints, would result in more organs for those with the greatest medical need, and thus would result in fewer deaths, according to the Health Resources and Services Administration.

The report provides numerous examples of the disparities, measured according to several different categories of patients. In some cases there are differences in waiting times even between adjacent areas. For example, the median waiting time for liver transplant patients with similar medical status was 439 days in the Baltimore area, compared with 147 days in nearby Washington, D.C.

For liver transplant patients with blood type O, the median waiting time was 511 days in New York City, while the median waiting time in bordering northern New Jersey was 56 days. Iowa, with the shortest waiting time among all 66 organ procurement areas at 46 days, compared with neighboring Nebraska at 596 days.

Differences also existed in organ recovery activity, with some organ procurement organizations reporting higher rates than others. HHS took action last year to require hospitals to report all deaths to their local organ procurement organization (OPO), thus providing more opportunity for OPOs to contact the families of potential donors and increase organ donation nationwide. In addition, the pending HHS regulation that would require changes in organ allocation policy would also help provide a fairer system for patients, regardless of differences in OPO recovery rates. ◆

The executive summary of *The 1997 Report of the OPTN: Waiting List Activity and Donor Procurement* can be accessed from UNOS's Web site at ***www.unos.org***. Organ-specific volumes may be ordered by calling UNOS at 804-330-8541. For specific volumes of the report, purchasers will be required to pay shipping and handling charges.

HCFA HEALTH watch

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration (HCFA) to provide timely information on significant program issues and activities to its external customers.

Nancy-Ann Min DeParle
Administrator

Elizabeth Cusick
Acting Director, Office of Communications & Operations Support

Joyce G. Somsak
Director, Communications Strategies & Standards Group

HEALTH WATCH TEAM

Jon Booth.....410/786-6577
Justin Dowling.....617/565-1261
William Kidd.....Relay: 800/735-2258
410/786-8609
Mildred Reed.....202/690-8617
DavidWright.....214/767-6346

Visit Our Web Site!
www.hcfa.gov

You may browse past issues of the *HCFA Health Watch* at ***www.hcfa.gov/news/newsltr.htm***. Also, should you wish to receive a hard copy, make an address change, or comment on an article, send your e-mail to ***healthwatch@hcfa.gov***.

Audit Shows Dramatic Decline in Improper Medicare Payments

The Department of Health and Human Services reports that improper Medicare payments to hospitals, doctors and other health care providers declined last year to the lowest error rate since the government initiated comprehensive audits three years ago. The findings are included in the Department's Office of Inspector General's audit report.

The error rate for fiscal year 1998, about 7.1 percent, represented estimated improper payments of $12.6 billion. In FY 1997, the error rate of 11 percent repre-

See **Audit,** page 5

Message from the Administrator

Nancy-Ann Min DeParle

EVERYONE WHO RELIES ON MEDICARE FOR THEIR HEALTH CARE or their loved ones' care is affected by waste, fraud and abuse in the program. All Americans pay the price for the small number of unscrupulous people who rip off the program.

To emphasize that point, the AARP has teamed up with the Departments of Health and Human Services and Justice to launch a nationwide education effort to help reduce Medicare fraud and abuse.

The "Who Pays? You Pay" campaign helps beneficiaries and taxpayers act as Medicare's eyes and ears. On February 24, officials trained thousands of beneficiaries in more than 30 cities nationwide to join this important effort.

The campaign urges beneficiaries to review their Medicare statements, which are sent by the private insurance companies that process and pay claims on behalf of Medicare. They should ask themselves three questions: Did I receive the services or products for which Medicare is being billed? Did my doctor order the service or product for me? Is the service or product necessary given my health condition?

If any answers are no, we urge beneficiaries to contact the health care provider or Medicare contractor to see if an error requires correction. If someone suspects fraud, they should contact the HHS Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477).

Most doctors, hospitals and other providers are honest, and they share our commitment to stopping fraud. They work hard to provide quality care and to bill Medicare appropriately. A billing error often is just an honest mistake.

By reviewing statements, beneficiaries can help Medicare and their health care providers correct those errors quickly. And they can help authorities identify the unscrupulous few who try to commit outright fraud.

Today, 39 million beneficiaries across America rely on Medicare. The program will pay about $210 billion for their health care this year. Medicare's contractors will process nearly 1 billion claims from more than a million doctors, hospitals, suppliers and other providers.

Those of us who run Medicare are doing our part to protect it.

We've toughened our standards for businesses to care for Medicare beneficiaries. We've clarified rules about how to bill the program. We've conducted more medical reviews and audited more claims. And we've offered rewards for tips that lead to fraud recoveries.

We're seeing the results now, and we're moving in the right direction. Medicare's latest audit shows that we've cut Medicare's error rate nearly in half in just two years — to 7.1 percent in Fiscal Year 1998 from 14 percent in Fiscal Year 1996. The audit covers everything from honest errors to outright fraud.

But we need to continue in our efforts to strengthen and protect Medicare. Beneficiaries can help by watching their Medicare statements and getting errors fixed promptly.

After all, who pays for those wasted dollars? We all pay as taxpayers and beneficiaries. The money saved will help keep Medicare strong for current beneficiaries, their children and grandchildren, and all other Americans. ◆

Selected Health Issue on the Web

http://www.guideline.gov

New Quality Resource for Health Professionals Launched

Department of Health and Human Services Secretary Donna E. Shalala recently launched the National Guideline Clearinghouse (NGC), an Internet-based source of information on clinical care that will assist health professionals to improve the quality of care they provide their patients. The NGC developed by the Agency for Health Care Policy and Research (AHCPR) in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP).

Thousands of clinical practice guidelines have been created by medical and professional societies, managed care organizations, hospitals, state and federal agencies, and others. However, clinicians and other users often have had difficulty gaining access to a full range of guidelines, and then identifying which guidelines are based on evidence. They also have had no efficient way of making comparisons to select the guideline that best meets their needs.

The NGC features evidence-based clinical practice guidelines presented with standardized abstracts and tables that allow for comparison of guidelines on similar topics. The tables provide information on the major areas of agreement and disagreement among guidelines, which will help users make informed selections. The NGC will also feature topic-related electronic mail discussion groups where guideline users can exchange information about different aspects of guideline development, content, and implementation.

To date, more than 500 clinical practice guidelines have been submitted to the NGC by physician specialty groups, medical societies, managed care plans, state and federal organizations, and others. The NGC criteria for selecting evidence-based guidelines was published in a *Federal Register* notice issued on April 13, 1998.

The NGC will continue to receive guideline submissions on an ongoing basis. Organizations wishing to submit a guideline, should contact Vivian Coates, ECRI, NGC Project Director, 5200 Butler Pike, Plymouth Meeting, PA 19462-1298. For questions about guideline submissions, please contact Jean Slutsky, NGC Project Officer, 301/594-4042 or via e-mail at ***jslutsky@ahcpr.gov.*** ◆

To find out more about AHCPR, its research findings and publications, visit the AHCPR home page at ***http://www.ahcpr.gov.***

Consumers Can Read Medicare Assessments

The results of a survey of more than 100,000 Medicare beneficiaries enrolled in managed care plans that participate in Medicare are now available on the Health Care Financing Administration (HCFA) Web site (***www.medicare.gov***). For the first time in Medicare's history, beneficiaries and their families can examine information assessing the quality of care provided by health plans contracting with the program as rated by other beneficiaries.

The new measures provide Medicare beneficiaries and the public with information to help them make decisions about how they want to get their health care. Providing such information is part of the Clinton Administration's approach to strengthening patients' rights and emphasizing the quality of care provided to consumers.

Between February and May 1998, HCFA sent detailed surveys to about 136,000 Medicare beneficiaries, asking them to assess the quality of their health plans. More than 100,000 beneficiaries completed the surveys, making it the largest consumer assessment survey of managed care ever conducted in the country. The survey was developed jointly by HCFA and the Agency for Health Care Policy and Research (AHCPR).

Beneficiaries were asked to indicate their satisfaction with their health plans. They rated their health plan on a scale of 1 to 10. Almost half of those surveyed rated their plan a "10" and another 34 percent gave their plan an "8" or a "9." Nearly 70 percent of beneficiaries said their doctors "always" communicate well with them and another 23 percent said their doctors "usually" communicate well.

A second national survey of Medicare beneficiaries was conducted by HCFA in the fall of 1998 and results are expected to be included in information mailed with the 1999 *"Medicare & You"* handbook. This fall, HCFA also plans to conduct a survey focusing on beneficiaries who leave their HMOs. In 2000, HCFA will survey beneficiaries who have chosen to remain in the traditional Medicare program.

In addition to the consumer assessments, HCFA recently released information from the first Medicare Health Plan Employer Data and Information Set (HEDIS) assessment of health plan quality. HCFA required plans to report 30 HEDIS performance measures and checked the seven measures most important to Medicare beneficiaries for accuracy. These include mammography rates, the use of life-saving beta blockers in heart-attack patients, and eye exams for diabetics. The National Committee for Quality Assurance (NCQA) developed HEDIS and collected the information from the health plans. The information was independently audited by the New York-based Island Peer Review Organization.

According to the HEDIS data, Medicare managed care plans reported that, on average, approximately three-fourths of women between the ages of 52 and 69 enrolled in a managed care plan in 1996 and 1997 had at least one mammogram. In addition, three-fourths of beneficiaries age 35 and older who survived a heart attack during 1997 and were eligible for beta blocker therapy received a beta blocker prescription when they were discharged from the hospital. Half of all beneficiaries age 31 and older with diabetes received an eye exam in 1997. Some people with diabetes can be screened safely less than once a year, suggesting an optimal rate below 100 percent. Variations in clinical results suggest that these standards of care are not achieved uniformly by Medicare managed care plans, and HCFA hopes that each plan will continue to improve on their results. ◆

Wisconsin and Hawaii CHIP Plans Are Approved

HHS Secretary Donna E. Shalala recently approved the Children's Health Insurance Program (CHIP) plans for Wisconsin and Hawaii. A Medicaid Section 1115 waiver that serves as a companion to the CHIP program for Wisconsin was also approved.

The second phase of Wisconsin's CHIP plan is known as BadgerCare. Medicaid expansion was approved on May 29, 1998. BadgerCare expects to enroll an estimated 23,000 children by October 2000, an increase over the state's current CHIP program, which is expected to enroll 1,300 children over the same period. The Medicaid waiver allows Wisconsin to enroll 27,000 adults who are the parents of children in BadgerCare.

Wisconsin is eligible to receive as much as $38 million in new funds for fiscal year 1998. The CHIP law allocates $24 billion over five years to help states expand health insurance to children whose families earn too much for traditional Medicaid, yet not enough to afford private health insurance.

Wisconsin and Hawaii, like all states with CHIP plans, will receive federal matching funds only for actual expenditures to insure children. To date, 50 state and territorial plans have been approved and Wisconsin is the 10th plan to have an amendment approved. Tennessee, Guam, and American Samoa have plans in the approval process now.

The first phase of Wisconsin's CHIP plan extended Medicaid coverage to children ages 15–18 in families with incomes of up to 100 percent of the federal poverty level (the federal poverty level is $16,450 for a family of four). The approved expansion will include all remaining children in families with incomes of up to 185 percent of poverty ($30,432.50) who are not currently covered by Medicaid. Once a family is enrolled, it can remain in the program until its income reaches 200 percent of poverty ($32,900). Families with incomes above 150 percent of poverty ($24,675) will pay a premium that will be between 3 and 3.5 percent of annual income.

Hawaii's CHIP program will augment the state's comprehensive health insurance coverage system already underway through a statewide Medicaid demonstration, QUEST, approved by the Clinton Administration on July 16, 1993. QUEST is attempting to provide universal coverage for state residents who are not covered under Hawaii's mandatory employer-sponsored insurance program.

The federal poverty level in Hawaii is $18,920 for a family of four. Hawaii will use its allotment to expand its existing Medicaid program coverage to children between the ages of 1 and 6 in families with incomes up to 185 percent of the federal poverty level ($35,002). The state's current Medicaid program covers children in this age group in families with incomes of up to 133 percent of poverty ($25,163.60). Hawaii plans to submit amendments in the future to incrementally increase coverage to more children. The benefit package will be the same as the state's Medicaid program benefit plan. There will be no out-of-pocket costs to families participating in the program.◆

Plan Options for States	
✓ design	new health insurance program
✓ expand	current Medicaid programs, or
✓ combine	both of the above

Elder Care Locator: Putting Telephone Callers in Touch with Information

The Elder Care Locator is a public service of the U.S. Administration on Aging. This toll-free telephone service puts callers in touch with information about state and area agencies, tribal organizations and private organizations serving the elderly in their own communities or anywhere in the country. The Elder Care Locator is administered by the National Association of Area Agencies on Aging and the National Association of State Units on Aging.

Older persons and their caregivers need the Elder Care Locator because it is the first step in finding necessary and convenient community services and resources. Information on some of the services provided include the following:

❒ Local home and community-based services, such as meal delivery, transportation assistance and chore services

❒ Housing options;

❒ Community senior centers;

❒ Adult day care and respite from daily caregiving responsibilities;

❒ Financial, legal services and elder abuse prevention programs;

❒ Specialized services for older individuals with Alzheimer's disease, cancer, heart disease and other illnesses.

Callers to the Elder Care Locator are greeted by a caring, highly trained information specialist. This person will ask for the county, city, or ZIP code of the elderly person in need of assistance, as well as a brief description of the problem or situation. Databases containing the following information are accessed:

❒ Hotlines and special services offered by state or area agencies, tribal organizations, community and/or private organizations.

❒ Referral/assistance providers serving the particular county, city or ZIP code of the person needing assistance.

Callers do not need to reside in the same area as the elder person in need of assistance. Callers are provided with information about the best resources and services available in the elderly person's community, including names, addresses and telephone numbers. Callers are provided with the most accurate and timely infor-

See **Elder Care,** page 6

Audit, from page 2

sented an estimated $20.3 billion; and 14 percent in FY 1996 for an estimated $23.2 billion in improper payments.

"The report by the Inspector General is welcome proof that our zero tolerance policy against waste, fraud and abuse is paying off," HHS Secretary Donna E. Shalala said. "We still have a big job to do in eliminating improper Medicare payments, but with a 45 percent reduction in improper payments in just two years, we are making real progress."

OIG auditors with the support of medical experts reviewed a comprehensive statistically valid sample of Medicare fee-for-service claim expenditures and supporting medical records to determine the accuracy and legitimacy of the claims. Auditors reviewed 600 beneficiaries nationwide with 5,540 claims valued at $5.6 million and determined that 915 of the claims did not comply with Medicare laws and regulations.

By projecting the sample results over the universe of Medicare fee-for-service benefit payments, which totaled $176.1 billion during the fiscal year, the OIG calculated that $12.6 billion was the midpoint in the estimated range of improper payments.

HHS Inspector General June Gibbs Brown called the 45-percent reduction in overpayments since FY 1996 "a truly remarkable improvement," and said she was "encouraged by the determined and concerted effort of the Secretary, the Health Care Financing Administration, the Department of Justice, the Congress and the provider community to effectively address the overpayment problem. This clearly demonstrates what can be accomplished when we work cooperatively to solve such significant problems."

She noted that the improper payments, as with past years, could range from inadvertent mistakes to outright fraud and abuse; the portion of the error rate attributable to fraud could not be quantified.

The two major problem areas were identified as billing for services that were not medically necessary and upcoding services to secure a higher reimbursement than justified. They combined to account for about $9.3 billion of the estimated $12.6 billion in improper payments. Another $2.1 billion in overpayments was attributed to documentation discrepancies, and the remaining $1.2 billion to billing for services not covered by Medicare, and other types of errors.

Inspector General Brown attributed the reduction in improper payments to several factors including improved program oversight and enforcement and greater compliance by health care providers with Medicare=s billing rules. She credited the HCFA for requiring more extensive prepayment reviews of types of claims identified as vulnerable to improper payments, and the provider community for working aggressively with the HCFA to better ensure that they understand and abide by the reimbursement rules.

"We are very pleased with this evidence of our substantial progress over the last year, even as we continue to accelerate our efforts against waste, fraud and abuse," said HCFA Administrator Nancy-Ann Min DeParle. I want to thank the Inspector General and our partners at the Department of Justice, as well as members of Congress who have helped give us the enforcement tools and financial resources necessary to turn the tide of waste and fraud in Medicare." ◆

New Regulations/Notices

Medicare Program; Negotiated Rulemaking; Coverage and Administrative Policies for Clinical Diagnostic Laboratory Tests; Announcement of Additional Public Meetings [HCFA-3250-N2] — Published 1/4. This notice announced additional public meetings of the Negotiated Rulemaking Committee on Coverage and Administrative Policies for Clinical Laboratory Tests. The meetings took place in January 1999.

Medicare Program; Open Town Hall Meeting to Discuss the Positron Emission Tomography [HCFA-3889-N] — Published 1/4. This notice announced meetings on the current medical and scientific evidence regarding the clinical use of positron emission tomography scans for cancers of the head and neck, colorectal malignancy, melanoma, lymphoma, and brain tumors. HCFA discussed the clinical comparability of dedicated positron emission tomography scanners compared to coincident imaging cameras. The meetings were held at the HCFA Single-Site Auditorium in Baltimore, Md. on January 20–21, 1999.

Medicare Program; Prospective Payment System for Hospital Outpatient Services; Extension of Comment Period [HCFA-1005-2N] — Published 1/12. This document extends the comment period to March 9, 1999 for a proposed rule published in the *Federal*

See **Regulations/Notices,** page 6

Calendar of Events

March 25 — Administrator Nancy-Ann Min DeParle speaks at the California Association of Health Plans in Palm Springs, Calif., on *The Future of Medicare.*

March 25 — 26 — National conference on the theme of *Older Adults, Health Information, and the World Wide Web,* co-sponsored by the SPRY Foundation and the University of Georgia Gerontology Center in cooperation with the National Institutes of Health, will be held at the Natchez Center, National Institutes of Health, Bethesda, Md. For more information on the program and registration, check at ***www.spry.org***.

March 30 — Deputy Administrator Michael Hash participates in HCFA's Hepatitis B Kick-off Event to be held at the South Cove Community Health Center in Boston, Mass.

April 15 — Administrator DeParle speaks at the 1999 Holocaust Memorial Ceremony at the HCFA Single-Site Auditorium in Baltimore, Md.

Regulations/Notices, from page 5

Register on September 8, 1998 (63 FR 47552). In that rule, HCFA proposed to eliminate the formula-driven overpayment for certain outpatient hospital services, extend reductions in payment for costs of hospital outpatient services, and establish in regulations a prospective payment system for hospital outpatient services (and for Medicare Part B services furnished to inpatients who have no Part A coverage).

Medicare Program; Update of Ratesetting Methodology, Payment Rates, Payment Policies, and the List of Covered Procedures for Ambulatory Surgical Centers Effective October 1, 1998; Extension of Comment Period [HCFA-1885-N] — Published 1/12. This document extends the comment period for a proposed rule published in the *Federal Register* on June 12, 1998 (63 FR 32290). In that rule, HCFA proposed to make various changes, including changes to the ambulatory surgical center (ASC) payment methodology and the list of Medicare covered procedures.

Medicare Program; Ambulance Fee Schedule; Intent to Form Negotiated Rulemaking Committee [HCFA-1002-NOI] — Published 1/22. Section 4531(b) of the Balanced Budget Act of 1997 (BBA) required that the Secretary establish a fee schedule for the payment of ambulance services under the Medicare program by negotiated rulemaking. HCFA was required to establish a Negotiated Rulemaking Committee under the Federal Advisory Committee Act (FACA) to negotiate a fee schedule for ambulance services. The Committee will consist of representatives of interests that are likely to be significantly affected by the proposed rule. This notice announced HCFA's intent to establish a Negotiated Rulemaking Committee and outlined the scope of issues to be negotiated by the Committee. Comments and requests for representation or for membership on the Committee were considered on February 22, 1999. The first meeting was held at Turf Valley Hotel in Ellicott City, Md. on February 22–24, 1999. ◆

Ambulance, from page 1

chair. Non-emergency ambulance services for beneficiaries who are bed-confined are presumed to be medically necessary.

The new rule allows round-trip ambulance services if medically necessary for beneficiaries with end-stage renal disease from their home to the nearest appropriate freestanding or hospital-based dialysis facility. Prior ambulance services for these beneficiaries were limited to hospital-based dialysis facilities.

In addition, Medicare in certain circumstances will now cover services provided by paramedics who operate separately from an ambulance supplier. The coverage of paramedic "intercept" services will be limited to rural areas where volunteer ambulance squads provide only basic-life support services and are prohibited by state law from charging for their services. Intercept services are typically provided by a paramedic who operates separately from an ambulance supplier and who provides advanced life-support services to a beneficiary. Previous Medicare policy lacked provisions to pay for these services separately from the ambulance service.

The Balanced Budget Act of 1997 requires the Health Care Financing Administration (HCFA) to: (1) use negotiated rulemaking to establish the Medicare ambulance fee schedule; (2) establish steps to control increases in expenditures for Part B ambulance services; (3) establish definitions for ambulance services that link payments to the type of services furnished; (4) consider appropriate regional and operational differences; and (5) phase in the fee schedule in an efficient and fair manner.

HCFA has taken various steps to ensure that Medicare pays appropriately for ambulance services. For example, a fraud alert on questionable billing practices has been released. HCFA has instructed Medicare contractors to assign new codes to indicate emergency or non-emergency services, basic or advanced life-support services; and whether an all-inclusive payment rate or base rate with mileage and supplies billed separately were used. These changes creates a consistent method to process claims and allows HCFA to collect specific information about what kinds of ambulance services are being provided to Medicare beneficiaries. ◆

Elder Care, from page 4

The Elder Care Locator can be reached by dialing toll-free, 1-800-677-1116, Monday through Friday, 9:00 a.m. to 11:00 p.m., Eastern Standard Time. The Elder Care Locator is not an automated, touch-tone information system. Callers speak to a friendly, caring person. ◆

Department of Health & Human Services
Health Care Financing Administration
7500 Security Boulevard, Mail Stop C5-15-07
Baltimore, Maryland 21244-1850

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, $300

First Class Rate
Postage & Fees
PAID
HHS Permit No. G-28